Thinking About the Individual Health Insurance Market In a Post-HIPAA Era

by

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TABLE OF CONTENTS

List of Tables

I. INTRODUCTION

Most Americans have health coverage most of the time, either through employer-sponsored group health plans or through public programs such as Medicare, Medicaid or a state Children's Health Insurance Plan. When they don't qualify for any of these, they look to the individual market as a source of coverage.[1]

Anyone can find himself or herself dependent on the individual market. Circumstances that commonly lead people to seek coverage in the individual market include aging off parents' coverage, getting a job without health benefits, self-employment, taking extended leave, becoming divorced or widowed from a worker with coverage, and retiring before the age of 65.

When people turn to the individual market, however, adequate and affordable coverage may not be there for them. Millions of Americans with serious health conditions – such as cancer, diabetes, or HIV/AIDS – would be denied if they applied for an individual health insurance policy today in most states. Many more with moderate to mild health problems could buy a policy, but only at increased rates and/or with riders that eliminate coverage for their condition. Over forty million Americans between the ages of 50 and 64, even if they were all in perfect health, would pay higher premiums due to their age.

Health- and age-related factors are not the only barriers to coverage in the individual market. Even when people can buy standard coverage at standard rates, that coverage tends to leave significant gaps. Strict limits are likely to attach to maternity benefits, prescription drugs, and mental health and substance abuse treatment, if these services are covered at all. Finally, health insurance in the individual market is more expensive than group coverage; and because consumers in this market must pay the full premium, affordability is a real issue. These problems for consumers in the individual market have created and continue to reinforce its status as an unreliable market of last resort.

States and the federal government have acted to respond to access problems in the individual market, but have learned that shoring up individual coverage is not easy. This market is small and therefore vulnerable to selection problems that can arise when access is extended to older and sicker participants. Further, public policy changes to strengthen the individual market can have significant spillover effects on group markets and public programs.

Because millions of Americans now rely on the individual market, and because some policymakers would turn to this market to expand coverage for the uninsured, individual health insurance merits study and consideration. This paper summarizes what experts know about the individual market. It reviews the history of key state and federal reform efforts. Then it poses ways to think about individual market reform – as a stand-alone policy initiative and in the context of broader coverage expansion initiatives. It concludes with recommendations for further study.

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[1] The term "individual" health insurance refers to private, non-group coverage and may include two-adult, adult-and-child, and family policies that also are sold in the individual health insurance market.

II. THE CURRENT INDIVIDUAL MARKET[2]

Who buys individual market coverage?

People generally come to the individual health insurance market only when they do not have access to employer-sponsored group health plans or to public programs. Most individual market participants are adults of childbearing age or children, at least middle-income (above 300% of poverty), employed, and live in urban areas. However, compared to the general population, a disproportionate number of individual market participants are early retirees, low-income, self-employed, part-time workers or non-workers, and rural residents – subgroups that are less likely to have access to employment based coverage, Medicare or Medicaid (Chollet, 2001).

Some people remain covered by individual health insurance for an extended period. Early retirees, for example, may need individual health insurance for five to ten years until they are eligible for Medicare. People who are self-employed may need individual health insurance coverage most or all of their working career. Others may participate in the individual market only briefly or intermittently. For example, a young adult may need this coverage when he no longer qualifies as a dependent under his parents' policy and until he finds a job with health benefits. Workers who rely on employment-based health benefits may need individual coverage if they take leave or reduce the hours they work, or if they change to a job without benefits. Estimates based on Census data suggest that at least one-third of individual market participants hold this coverage for less than one year (Chollet and Kirk, 1998). However, more detailed data are needed to shed light on how many people seek individual market coverage during a year or in the course of a lifetime, how often people participate in this market, how long they stay in the market, why they leave, and how frequently they change coverage.

Overall, as many as 16 million people held individual health insurance coverage for all or part of the year in 1998. (See Table 1) The number of people with individual coverage has declined steadily since 1993 (from 16.6 million persons to 15.8 million in 1999) as job based health coverage has expanded. Just 6.6 percent of the non-elderly population reported having individual health insurance at any time during 1999 (Fronstin, 2000).

[2] A companion paper to this document, written by Deborah Chollet, reviews the academic literature on the individual health insurance market and offers more detail about its structure and its participants. See http://aspe.hhs.gov/health/reports.

Table 1
Sources of Health Insurance Coverage among the Nonelderly Population, by Selected Characteristics of the Insured Individual: 1999

Population characteristics	Total population under age 65 (millions)	Employer-based insurance		Individual insurance		Uninsured	
		Percent of population	Percent of employer-insured population	Percent of population	Percent of individually insured population	Percent of population	Percent of uninsured
Age:							
Less than 18	71.5	65.5%	28.7%	55.4%	23.9%	13.8%	23.7%
18 - 24	26.2	58.9%	9.5%	5.6%	9.1%	29.1%	18.3%
25 - 44	81.6	70.6%	35.3%	6.1%	30.9%	19.7%	38.4%
45 - 54	36.5	75.4%	16.9%	8.3%	18.9%	13.3%	11.6%
55 - 64	23.4	67.4%	9.7%	11.8%	17.2%	14.4%	8.1%
Family income as a % of poverty:							
0-99 percent	29.6	21.3%	3.9%	4.5%	8.2%	35.3%	25.0%
100-199 percent	40.9	47.7%	12.0%	6.8%	17.2%	29.3%	28.6%
200-299 percent	40.3	70.5%	17.4%	7.0%	17.5%	19.1%	18.4%
300-399 percent	34.0	80.3%	16.7%	6.7%	14.1%	12.4%	10.1%
400 percent +	94.4	86.6%	50.0%	7.3%	42.9%	7.9%	17.9%
Residence:							
Metropolitan	194.6	68.8%	82.0%	6.3%	76.9%	17.6%	81.9%
Nonmetropolitan	44.7	65.6%	18.0%	8.3%	23.1%	16.9%	18.1%
Work status of family head:							
Full-time full-year wage/salary worker	158.1	80.3%	77.7%	4.3%	42.6%	13.4%	50.8%
Other wage/salary worker	36.8	51.6%	11.6%	7.3%	16.8%	25.6%	22.5%
Self-employed worker	17.9	51.2%	5.6%	23.9%	26.7%	22.4%	9.6%
Non-worker	26.5	31.2%	5.1%	8.4%	13.9%	27.0%	17.1%

Source: Author's tabulations of the March 2000 Current Population Survey (U.S. Bureau of the Census).

What coverage is for sale in the individual market?

A broad range of major medical health insurance products are for sale in the individual market.[3] The most popular policies cover a relatively comprehensive set of health care services – such as hospital and physician care, diagnostic services, and prescription drugs – with lifetime limits of $1 million or higher. However, many, if not most major medical policies in the individual market leave significant gaps in coverage. Cost sharing options vary extensively from policy to policy and can be quite high. Coverage for certain health services or health conditions can be subject to separate "inside limits," or excluded from policies altogether (Pollitz, Sorian, and Thomas, 2001; Chollet and Kirk, 1998). Some coverage limitations typical in the individual market include:

> Maternity benefits generally are not covered under individual health insurance policies, except where required by law. When maternity coverage is available, typically it is sold separately as an amendment (called a "rider") to the main policy. Maternity riders add only partial coverage (for example, benefits may be capped at $3,000/year) and in most states require waiting periods of a year or longer before maternity coverage begins. Insurers expect a high degree of adverse selection when they sell maternity coverage as an optional rider: that is, most people who buy the maternity rider expect to become pregnant. Consequently, maternity riders generally offer prepayment for maternity care and have little insurance value.
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> Mental health and substance abuse treatment, when covered, is usually subject to strict limits that leave policyholders with open-ended liability for this care. Separate lifetime limits on covered services, as low as $10,000, are common. In addition, individual policies typically limit the number of inpatient days and outpatient visits that are covered each year and also require patients to pay higher cost sharing for these services. Fifty percent coinsurance for outpatient care is typical. Some policies also cap service-specific benefits – for example, $25 per outpatient visit or $175 per day for inpatient care. Others impose special coverage limits on prescription drugs to treat psychiatric disorders. Frequently, substance abuse treatment is not covered at all. To improve individual market coverage for mental health care, some states have passed partial mental health parity laws requiring care for severe, biologically based mental disorders to be covered as any other health condition.
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> Prescription drug coverage typically is included in individual market policies, though not always. In some policies the benefit is small – for example, capped at $1,000 per year. In others there is a separate deductible for prescription drugs. Many insurers use the drug benefit as an underwriting tool. For example, a person suffering from depression might be issued a policy that excludes coverage for psychiatric drugs. Other policies offer a drug card that is available only to enrollees who can pass medical underwriting. Enrollees who have the card pay a

[3] This analysis is confined to comprehensive, major medical insurance policies. Other kinds of coverage are for sale, however, such as cancer policies and other dread disease coverage, as well as short term, non-renewable individual health insurance policies.

flat co-pay (for example, $10 for generic prescriptions and $30 for brand drugs) for their prescriptions. For those who don't qualify for the drug card, prescriptions are subject to an annual deductible and coinsurance.

Benefits related to specific high-cost conditions or services may be limited under individual market policies. For example, lifetime limits on HIV/AIDS (as low as $10,000) may be imposed where not prohibited by law. Separate lifetime limits may also be imposed for organ transplants. Separate benefit limits on home health care and rehabilitation therapy are common.

The variety of policy designs in the individual market appears to favor consumer choice. But choice can limit options for consumers if benefit design differences cause consumers to segregate into risk categories. When people who expect to need health care gravitate toward more comprehensive coverage, insurers respond by raising the price of coverage, restricting its availability, or both. The dearth of coverage for maternity benefits and the tight eligibility and coverage limits typically imposed on prescription drugs and mental health are evidence of insurer behavior to protect against adverse selection.

In response, many states have enacted benefit mandates to ensure that services such as childhood immunizations, breast reconstruction, or emergency room care are uniformly available in all individual policies. However, benefit mandates have been criticized as increasing the cost of insurance. A few states require insurers in the individual market to sell standardized policies. Standardization helps consumers to compare prices for like policies and eliminates adverse selection based on benefit design. However, it also eliminates the opportunity for consumers to choose a cheaper policy that covers less.

What does individual health insurance cost?

Given the high degree of policy design variation in the individual market, it is not surprising that the price of coverage varies enormously. Thus, any one "benchmark price" is usually a poor measure of available prices.

The advertised price for a health insurance policy is called the "standard rate." Of course, standard rates for individual health insurance vary by benefit design. However, applicants for identical coverage might pay very different premiums reflecting differences in their age, gender, where they live, and (as discussed in a later section) on their health status.[4]

Older consumers can expect to pay premiums three to five times those charged younger consumers in the individual market (Pollitz, Sorian, and Thomas, 2001). Except where prohibited or limited by law, all individual health insurance is age-rated. This makes the cost of coverage especially high for people in their late fifties and early sixties – the age cohort that relies most heavily on individual health insurance.[5]

[4] Some carriers also rate by the applicant's occupation, but this is less common.

[5] According to the March 2000 Current Population Survey, the average household income for people ages 60 to 64 is only 17% higher than for people ages 25 to 29.

Gender rating is also common where it is not prohibited by law. During their childbearing years, women pay higher standard rates than men; at older ages men are charged more for coverage than women.

Insurers set standard rates specific to a geographic market, often by clustered or individual zip code. In general, health insurance is more expensive in large urban areas than in rural communities, reflecting local differences in health status and health care use and costs. However, in some communities, premiums are dramatically higher than in others. For example, in Miami, Florida national carriers price policies at about twice the amount they charge in other large metropolitan areas (Pollitz, Sorian and Thomas, 2001).

Premiums can rise significantly from year to year. Rate increases may reflect changes in covered benefits, changes in the average experience of the insured class, and also strategic decisions by carriers – for example, to suppress rate increases in order to "buy"market share or to quote very high rates for new business instead of formally closing a product. State insurance regulators typically discourage insurers from re-rating individuals for changes in health status, but this protection is not generally codified in statute. If insurer underwriting (described below) makes it impossible for individuals to change insurers or products, they may find themselves captive in a product and rate class with premiums that rise steeply.

Taken together, the impact of age, gender, geography and policy design produces a wide scatter of standard premiums in the individual market. However, how many people actually pay even these standard rates is unknown. Many may pay a mark-up on the standard rate to reflect differences in health status, magnifying the variation in rates that policyholders actually pay.

Finally, the cost of individual health insurance generally is high relative to the cost of group coverage. Individual coverage is more expensive relative to benefits paid in part because carriers market to consumers (not employers) and underwrite applicants one at a time. One estimate of the average loading fee on individual coverage (based on data from the Health Insurance Association of America) was more than three times that on group coverage (Phelps, 1992). Further, the direct price of individual coverage per premium dollar is higher to consumers: they pay the entire premium out of pocket with no employer contribution, and they typically do not enjoy the same tax advantages for health insurance expenditures as they would in the group market.[6]

Underwriting in the individual market

People who apply for individual health insurance may encounter significant obstacles to becoming insured. Some may be denied coverage altogether. Others may be offered only substandard policies with special coverage restrictions, and they may face steep premium increases because of their health status or health history. The process of

[6] While expenditures for individual health insurance will soon be fully deductible for self-employed individuals, most individuals who do or would buy individual coverage are employed workers and are not self–employed (Chollet and Kirk, 1998).

evaluating an applicant's health status and risk of future health care use is called medical underwriting. Except where prohibited by law, insurers use medical underwriting extensively in the individual market, limiting who can buy standard coverage at standard rates.

Denial of coverage – People with severe health problems – such as HIV/AIDS, cancer, diabetes, or multiple sclerosis – will consistently be refused coverage in the individual market unless state or federal law provides otherwise. However, a person with health problems as benign as hay fever might also be rejected (Pollitz, Sorian, and Thomas, 2001). Carriers' underwriting practices in the individual market vary, and each carrier may change its underwriting strategy to serve its current market strategy.

Substandard coverage – While people with mild to moderate health problems often can buy coverage, they frequently are offered substandard coverage, substandard rates, or both.[7] Most often, insurers create substandard coverage by attaching an amendment (called an exclusion rider) to a standard policy so that it specifically excludes coverage for one or more named health conditions. For example, an applicant with asthma might be offered a policy that excludes coverage for asthma. Sometimes exclusion riders are broader, excluding coverage for an entire body part or system related to the health condition (such the respiratory system). Instead of or in addition to exclusion riders, people with health conditions might be offered health insurance with higher cost sharing; for example, they might be issued coverage with a higher deductible or no drug card. These riders and additional cost sharing provisions often are permanent, but sometimes the insured can apply to have them removed if the health problem eventually is resolved. When people are issued coverage with an exclusion rider or greater cost sharing, they may find themselves underinsured. One recent study found that underinsurance occurs systematically among people with chronic illness (Stroupe, Kinney, and Kneiser, 2000).

Substandard Rates – Alternatively, an insurer might offer coverage at a higher than standard premium (sometimes referred to as a substandard premium or a rate-up) to an applicant with health problems. In states that do not regulate individual market premiums, rate-ups in the range of 25 to 50 percent are common. Rate-ups exceeding

[7] As is true under group coverage, people with health problems buying individual insurance also may face pre-existing condition waiting periods (sometimes called a "pre-ex"). However, pre-ex rules in many state individual markets are different than in the group market. Twelve states and D.C. impose no limits on pre-existing condition waiting periods. Seven more states set a maximum limit of 2 years or longer. In many states, the definition of a pre-existing condition is different in the individual market, as well. A health condition that was never before discovered can be considered pre-existing if some symptoms appeared (in some states, at any time) prior to coverage and, in the insurer's judgment, a prudent person would have sought medical advice or treatment for those symptoms. By contrast, in the group market, a condition is pre-existing only if the insured actually received a diagnosis, treatment, or medical advice for it sometime during the 6 months prior to joining the health plan. Most states that limit pre-existing condition waiting periods nonetheless permit the imposition of permanent exclusion riders. Only nine states prohibit all exclusion riders (Michigan prohibits exclusion riders for specified medical conditions); 27 states limit the look-back and/or waiting period for preexisting condition exclusions, but allow exclusion riders (See www.healthinsuranceinfo.net).

100 percent are less common; carriers typically reject applicants judged to be more than twice the standard risk. However, where insurers must guarantee issue coverage but are unconstrained in the rates they may charge (as is the case under HIPAA for federally eligible individuals in several states), rate-ups of 400 to 600 percent are common (GAO, 1998 and 1999) and premiums as high as 2,000 percent of the standard rate have been documented (Pollitz, Tapay, Hadley and Specht, 2000).

Barriers to access for people with health problems – People with health problems can face immense barriers to finding health insurance, particularly in states that do not restrict whether and how insurers may underwrite. A forthcoming study for the Kaiser Family Foundation tested access to individual market coverage in eight markets for seven hypothetical applicants in less-than-perfect health (Pollitz, Sorian and Thomas, 2001). The applicants ranged in age from 24 to 62, and had health conditions ranging from hay fever to HIV. These hypothetical applicants applied for individual coverage in markets that impose few if any restrictions on medical underwriting practices. Together, they submitted 420 applications for coverage, but received only 43 "clean" offers for standard coverage at standard rates. The youngest, healthiest applicant ("Alice," a 24 year old woman with hay fever) was almost always offered coverage, but nearly all of her offers were substandard – involving an exclusion rider, a rate-up, or both. Five times her application was rejected. When she was offered coverage, the annual premium ranged from $408 to $4,596. By contrast, "Greg" (who was HIV+) was declined every time. All other applicants experienced a mix of denials and offers, and they were quoted a broad range of premiums (See Table 2).[8]

[8] The aggregated results in eight markets hides the variation in access to coverage across markets. For example, Alice's three clean offers occurred in only two markets; in six others she received no offers of standard of coverage at standard rates. Only two of the hypothetical applicants were able to obtain at least one clean offer in every market where they applied. One of those two applicants was also denied at least once in every market.

Table 2
Underwriting Actions by Individual Market Health Insurers
for Seven Hypothetical Applicants with Various Health Conditions

Applicant	Offers (on 60 Applications in 8 Markets)					Lowest vs. highest premium quoted (annual)
	Reject	Standard coverage at standard rates	Rate-up	Rider or other coverage limit	Rate-up and coverage limit	
Alice, 24, hay fever	5	3	6	42	4	$408 to $4,596
Bob, 36, knee injury	7	15	4	33	1	$588 to $5,112
Crane Family, 36, son with asthma and healthy daughter	9*	3	5	31	12	$1,692 to $15,444
Denise, 48, 7-year breast cancer survivor	26	11	5	5	13	$1,464 to $16,344
Emily, 54, depression	14	9	14	7	16	$1,920 to $10,992
Frank, 62, smokes, hypertensive, overweight	33**	2***	22	0	3	$2,928 to $30,048
Greg, 36, HIV+	60	0****	0	0	0	n/a

* The entire Crane family was never rejected; however, 9 times carriers offered to sell the family a policy that would cover the parents and their daughter, but not their son.
** Includes one rejection from a carrier that issues no coverage for people this age.
*** These two offers were at the carriers' higher smoker-standard rates.
****Greg should have been offered coverage by one carrier required by law to guarantee issue coverage; however, that carrier declined to participate in this survey.
Source: Pollitz, Sorian, and Thomas, 2001.

Uncertainty – Medical underwriting is an inexact science. The same person might get a standard offer of coverage from one carrier, a substandard offer from another, and rejected by yet another. Thus, unless state law requires guaranteed issue, consumers applying for coverage do not know whether they will be offered a policy or what the policy might cover or cost. Agents and brokers might advise a consumer about the likely outcome of medical underwriting, but the only way to know for certain about the availability and terms of coverage is to apply. The application process takes from two to eight weeks, and it can be both expensive and risky. Consumers must submit a check for one month's premium with the application, and any rejections for coverage must be disclosed on subsequent applications to other carriers. These practices constrain consumers in shopping for coverage; in practice, they are unable to know or compare the products and prices available to them.

Long-term effects – Not only does medical underwriting limit entry into the individual market, it makes it difficult to change policies. People who need to change policies (because of a move or change in family status, or because their doctor changes health plans or their health plan closes) are vulnerable if they have any health problem. They may be unable to obtain any new coverage at all. If they can find new coverage, it is

likely to entail a pre-existing condition waiting period, an exclusion rider, or both; and the price (reflecting their current health status) may be unaffordable.

There are not good data on the movement of consumers within the individual market. Estimates from the Current Population Survey suggest that at least one-third of policyholders may keep their coverage less than one year. Turnover in the individual market appears to be about 10 times greater than in group coverage (Chollet, 2000). However, the number and characteristics of people who surrender individual market coverage for coverage in the group market or a public program, or to become uninsured, is unknown. Other studies suggest that many who buy individual health insurance are inclined to keep it even in the face of steep premium increases (Marquis and Long, 1995). Given the cost and complexity of shopping for individual health insurance and the uncertainty of access and affordability in this market, this behavior would not be surprising.

Who sells individual market coverage?

Nationwide, there are many fewer insurers in the individual market (in 1997, 690 insurers by state) than in the group market (2,450). However, the number of carriers in the very small individual market is very large relative to the size of the market. On average, each carrier in the individual market wrote only 1/5 as much business as each carrier in the group market in 1997 (Chollet, Kirk and Chow, 2000).[9]

In every state, the market is highly concentrated: just three carriers account for 50 to 100% of the entire market. Collectively, the smallest half of insurers hold less than 8% of the market in every state. Blue Cross Blue Shield is typically the dominant carrier, holding at least half of the market in every state. HMOs are less dominant than in the group market (in half the states, holding less than 10 percent of the market), although their market share is growing.

Small-population states characteristically have a larger number of carriers than larger states relative to their population size. California, the largest state individual market, has about 5 million participants (full- or part-year) and in 1997 had 24 carriers – just 2 carriers per million population under age 65. One of the smallest-population states, Wyoming, had 7 carriers – equivalent to about 17 carriers per million population under age 65 (Chollet, Kirk and Chow, 2000).

Considering both the small size and the concentration of these markets among the few largest carriers, a surprisingly large number of very small carriers manage to survive. Many are national commercial insurers that write a small amount of coverage in each of many states. The niche they command in these states appears to rely heavily on underwriting, accepting fewer and healthier enrollees. As a result, they are able to

[9] For example, Wyoming had 7 carriers in its individual market in 1997 – equivalent to about 17 carriers per million population under age 65. This compares to California's 24 carriers, averaging just 2 carriers per million population under age 65.

compete successfully with larger carriers that achieve greater economies of scale and, therefore, can offer coverage at lower average cost than smaller carriers.

In response to market or regulatory pressure to become more efficient, there is evidence of growing consolidation in the individual market, with some (usually small) carriers merging or leaving altogether (Chollet, 2001). However, the exit of just a few insurers from small-population states may cause political momentum for repeal of state reforms.[10]

In summary, the individual health insurance market is where people turn when they do not have access either to employer coverage or public coverage. Many find this market a difficult place, however. It seems to offer extensive choice, but for most people who would buy in this market, it is expensive, complex and frustrating. Age, gender, and geographic rating make the price of coverage very low for some people, but very high for others – including the aging baby boom population. Medical underwriting makes access and cost uncertain for people who have even routine health problems.

At any point in time, relatively few people rely on this problematic market. Even so, participation has declined steadily, though modestly, since 1993. Many who left this market may have done so gladly as they found a job with health insurance benefits or became eligible for public coverage. Others may have left the individual market less happily – taking jobs they didn't want to get health benefits or becoming uninsured.

The individual market arguably is most difficult when carriers compete to select favorable risks. The very large number of carriers in every state relative to the size of the individual market causes nearly all insurers to operate at inefficiently small scale and heightens their need to risk select. In many states, the individual market is consolidating; in most, carriers are merging, but in some they are leaving the market. In nearly all cases, the smallest insurers are most likely to merge or exit, and they surrender very little market share when they do so. A continued focus on cost containment (and in equity markets, on insurers' earnings growth and profits) may force further consolidation in the individual market. However, further consolidation may also force regulators in many states to intervene in this market in unaccustomed ways – to regulate insurers' methods, prices and profits directly, instead of relying on competition to do so. The following sections of this paper review federal and state efforts to regulate individual health insurance markets.

[10] For example, at this writing New Hampshire is in the process of repealing guaranteed issue in the individual market on the strength of insurer arguments that it had caused insurers to exit the market. Like other states, New Hampshire has seen a significant decline of covered lives in the individual market, as covered lives grew in the group market. However, the exit of three of New Hampshire's six insurers from the individual market allowed the remaining insurers, in effect, just to maintain the market average volume of business as covered lives moved out of the individual market (Chollet, 2001).

III. EXPERIENCE WITH INDIVIDUAL MARKET REFORM

Some states have adopted substantial reforms to safeguard access to coverage in the individual market. Other states have done very little. Many fall somewhere in between. Congress has established a national floor of protections, but to date they are limited and leave most problems in the individual market unresolved.

Different kinds of people are protected by the various federal and state reforms. Federal reforms and many state reforms target only people who are leaving the group market. However, some state reforms are broader, helping people who seeking individual coverage for the first time or those who want to change policies within this market. This review of reforms enacted at the federal and state levels yields some lessons about what has been effective and what remains to be done.

Federal Reforms

The Consolidated Omnibus Reconciliation Act of 1985 (COBRA)

The first federal protection for people leaving group coverage allowed them to stay in the group health plan, forestalling entry into the individual market. COBRA requires all group health plans with 20 or more employees to allow participants leaving the plan to pay for continued coverage, if they would be leaving because of a change in work status (such as retirement or layoff) or family status (such as divorce or attaining majority age).[11]

However, "COBRA-coverage" is temporary. People who qualify for COBRA coverage due to a change in work status are guaranteed up to 18 months of continuation in the group plan. (For certain individuals who become disabled within the first month of COBRA coverage, this can be extended to 29 months.). When the qualifying event is a change in family status, COBRA continuation is guaranteed for as long as 36 months.

Those who qualify for continuation coverage must pay the entire premium (not to exceed 102 percent of average plan cost), including the share formerly paid by the employer. As a result, only about one in five people eligible for COBRA coverage elect it. Nevertheless, the access it offers is important for people leaving group plans who might otherwise might be unable to find or afford individual market coverage because of their health status or age. Among eligible people age 61 or older, the COBRA election rate is 38 percent (Flynn, 1992 and Loprest 1997). Among early retirees who have no other coverage options, COBRA election is as high as 75 percent (Gruber and Madrian, 1993). At any given time, an estimated 4.7 million people rely on COBRA for their health coverage (Levitt and Gabel, 1999).

[11] Attainment of Medicare eligibility by the primary covered worker is also a COBRA qualifying event, entitling the worker's dependents up to 36 months of continuation coverage.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA)

More than a decade after enacting COBRA, Congress addressed access to individual coverage for people leaving group health plans. HIPAA was an incremental measure, adopted in the wake of the failed comprehensive reform efforts of the Clinton Administration. HIPAA established access protections for certain federally eligible individuals. To be federally eligible a person must have had at least 18 months of continuous coverage, be leaving a group health plan, have elected and exhausted any available COBRA continuation coverage, and have applied for individual coverage within 63 days of the loss of group coverage (among other requirements). Carriers in the individual market must sell coverage to federally eligible individuals on a guaranteed-issue basis and with no pre-existing condition exclusions. However, HIPAA did not limit the price of this guaranteed issue coverage, and carriers can and have engaged in deterrent pricing of HIPAA products to make them unaffordable (Pollitz, Tapay, Hadley and Specht, 2000, and GAO, 1999). HIPAA also required all individual market coverage to be guaranteed renewable, but – as with portability coverage – it did not constrain renewal premiums.

HIPAA gave the states considerable flexibility to adopt alternatives to federal individual market access protections, and most did. This flexibility was so broad, it permitted states to use whatever market reform approaches they already had in place as their "alternative mechanism." Only a handful of states took the opportunity HIPAA presented to expand access to individual market coverage beyond what they had accomplished prior to 1996. In all other states, people's protected access to individual market coverage is about the same as it was before HIPAA.

The politics of HIPAA contributed to its limitations. Having failed to pass the Health Security Act, Congress wanted to enact real reform, but also strongly wanted to avoid overreaching. In this environment, settling on modest incremental reform was inevitable. Congress also was cognizant of the fact that states, not the federal government, have been the traditional regulators of private insurance markets. Thus, it both set a very low federal floor of federal protections and gave states considerable flexibility in how to achieve those protections. In response, many states went only as far as Congress required. A few failed even to adopt HIPAA's minimum reforms, defaulting to federal regulation.

HIPAA's group market reforms provide a marked contrast to its reforms in the individual market. Almost all states had enacted some small-group market access and rating reforms by 1996, but HIPAA set a floor of group market protections higher than many states had adopted. In particular, HIPAA required guaranteed issue for all policies sold in the small group market, while most states had required guaranteed issue of only a basic and standard plan. Thus, where many states had acted (albeit to widely varying degrees), the Congress was emboldened to set a higher national floor protecting access to private coverage. And, once this higher floor was universally required, states responded by rising to it. As a result, people's protected access to group coverage is much more uniform across states, as is their ability to move between health plans. In contrast, in the individual market, access to coverage still very much depends on where one lives.

Even with the limited scope of HIPAA's reforms in the individual market, problems with implementation have limited its effectiveness. The public is largely unaware of HIPAA protections; and even where they have heard of HIPAA, they are confused about what it provides (GAO, 2000). Some people are not receiving certificates of creditable coverage that prove HIPAA eligibility in a timely manner, or at all. This compounds the public awareness problem. Resources for federal oversight, data gathering, and enforcement have been insufficient, and coordination between multiple federal implementing agencies has been a challenge (Pollitz, Tapay, Hadley and Specht, 2000).

Nevertheless, HIPAA did lay groundwork for future reform. It established the concept of a federal floor for state regulation of the individual market that can be developed and strengthened. The federal floor of group market protections has reinforced state regulator authority and made it somewhat harder for some problem carriers to engage in "hit and run" tactics across states. In the future, the federal government could act to broaden individual market protections across states and make them more consistent, as HIPAA accomplished in the group market.

Finally, HIPAA also established a federal infrastructure to regulate private markets, although actual capacity is still in formative stages. While new cooperative partnerships between federal and state insurance regulators are embryonic, they could become stronger and more effective over time.

State Reforms

There are almost as many varieties of state individual market reform as there are states. The states have adopted these reforms in response to the kinds of access barriers that were described in the first section of this paper.

State laws vary in whether and how they require coverage to be sold on a guaranteed issue basis, limit preexisting condition exclusion periods, limit premiums, define the benefits that policies must cover, and how they combine these reforms. For purposes of this paper, it is useful to group state laws by how they protect access to health coverage for people who might not otherwise be able to pass medical underwriting in the individual market. Viewing state laws through this lens, the range of approaches is apparent (See Table 3).

A few states provide no access protections beyond what HIPAA requires. Conversely, a few states guarantee access to all products sold in the individual market for all residents year round. These comprehensive reform states also set standards for what individual market policies must cover and the premiums that can be charged.

Between the minimal reform states and comprehensive reform states are the majority of states that have enacted some access reforms, but do not support access to all products in the individual market. Twelve states protect access to coverage more broadly than HIPAA requires (including setting standards for coverage content and rates). In these

Table 3
State Individual Market Reform Approaches

SUMMARY	STATES	NOTES
Comprehensive (5)	ME, NH, NJ, NY, VT	All products must be guaranteed issue, with standards for covered benefits and limits on rating and pre-ex, for all residents, all year
Portability (5)	ID (hybrid with high risk pool) IA (hybrid with high risk pool) MA (hybrid with open enrollment) SD, RI*	At least some products must be guaranteed issue, with standards for covered benefits and limits on rating and pre-ex, for all residents with prior coverage, all year
Conversion (8)	FL, GA, NV, CA (hybrid with high risk pool) MN (hybrid with high risk pool, and open enrollment) MT (hybrid with high risk pool) OH (hybrid with open enrollment) OR (hybrid with high risk pool)	At least some products must be guaranteed issue, with limits on rating and pre-ex, for residents with prior group coverage, all year
Designated Carrier (4)	HI, MI, PA, VA	Selected carrier(s) must guarantee issue coverage (not necessarily with standards for covered benefits or limits on rating or pre-ex) for all residents, all year
Open enrollment (3)	DC, MD, WV	At least some carriers must guarantee issue coverage for all residents during limited times, not necessarily with standards for covered benefits or limits on pre-ex or rating)
High Risk Pool Only (21)	AK, AR, CO, CT, IL, IN, KS, KY, LA, MS, MO, NE, NM, ND, OK, SC, TX, UT, WA, WI, WY	Public program sells coverage to uninsurable individuals.** Varying rules for eligibility, rates, covered benefits, pre-ex
Minimal (5)	AL, AZ, DE, NC, TN	Access to non-group coverage protected only for HIPAA eligibles, with limits on pre-ex, but not for covered benefits or rates, all year
Group of One (13)	CT, DE, FL, MA, NH, VT, WA (All products/all year) AZ, CO, MD, ME, NC, RI (some products and/or limited times only)	Self-employed can buy small group coverage; some or all small group market protections for covered benefits, rating, pre-ex attach
Mini-COBRA (36)	AR, CA, CO, CT, FL, GA, IL, IA, KS, KY, LA, ME, MD, MA, MN, MS, MO, NE, NV, NH, NJ, NM, NY, NC, ND, OH, OR, RI, SC, SD, TN, TX, UT, VT, WI, WY	Temporary continuation of coverage guaranteed for eligible people leaving fully insured small employer plans

* Rhode Island has no rating limits.
** 19 of these states also guarantee high-risk pool access to HIPAA-eligible individuals.
Source: www.healthinsuranceinfo.net .

states, protections are primarily for residents with prior coverage, although seven use a hybrid approach that combines portability protections with other kinds of access guarantees. A few states still rely on one or more carriers of last resort to guarantee access to individual market coverage. Slightly more than half of the states have established high-risk pools for "uninsurable" residents whom individual market carriers refuse to cover. Finally, beyond the individual market, many states guarantee access to continued coverage in the small-group market for employees of very small firms which COBRA exempts.

Comprehensive Individual Market Regulation

Some states require all carriers in the individual health insurance market to offer all products on a guaranteed issue basis to all residents all year. The states that have adopted this comprehensive approach, shielding consumers from medical underwriting in finding coverage, also limit or prohibit premium variation based on health status, requiring community rating or pricing within "rate bands" defined in statute. Carriers also are required to offer standardized policies, sometimes exclusively, to limit risk-selection by benefit design and to help consumers compare prices.

Only five states (NH, NJ, NY, KY, VT) have this kind of comprehensive individual market regulation in place currently, although several others enacted this approach and then abandoned it. At this writing, New Hampshire appears to be in the process of repealing its comprehensive individual market reforms, as well.

The states that adopted comprehensive regulation did so primarily in response to a financial crisis by Blue Cross or other carriers of last resort. Another state (WA) changed regulation of its individual market as part of a broader effort to expand coverage and control costs throughout the health care system.

The experience of these states suggests that comprehensive reform of the individual market on a state-by-state basis is difficult, at best. Two factors, largely beyond the control of regulators, complicate individual market reform. First, most state individual markets are small, and some are tiny. The smallness of these markets, broken up among relatively many insurers, makes it harder to spread risk. Second, the politics of individual market reform can be intense, and inflammatory rhetoric often clouds debate about complex issues.[12] Further, in some states, the insurance industry has won concessions that compromise the access and risk-spreading that reform was intended to achieve. For example, in most states that limit pre-existing condition exclusion periods in the individual market, insurers are nonetheless permitted to use exclusion riders to permanently deny coverage for named health conditions.

[12] For example, one commercial carrier staged a demonstration to publicize its intent to exit the Vermont health insurance market following that state's adoption of market reforms. The company held a press conference on the capital steps featuring live weasels named for pro-reform government officials.

These following sections highlight key issues in several state comprehensive reform experiences. New York can claim some success with comprehensive individual market reform, primarily due to well-designed reforms and the large size of that state's market. New Jersey initially enjoyed similar successes with its comprehensive individual market reform, but the smaller size of its market appears to be problematic and New Jersey is now experiencing significant problems. Finally, Kentucky and Washington are examples of states that enacted comprehensive reforms only later to repeal them.

New York – In 1992, New York enacted simple, sweeping and comprehensive individual market reforms. Now, with substantial experience behind it, New York's success appears to be mixed.

The key policy design features of New York's individual health insurance market reform law include:

- guaranteed issue of all products,
- pure community rating (no variation for health status or age),
- standardized, comprehensive policies that must be offered by all carriers
- limits on pre-existing condition exclusion periods and prohibition of riders
- portability reforms to require credit for prior coverage

There are many signs of success under New York's individual market reform. Comprehensive coverage is reliably available; nobody can be turned down because of their health or risk status. Consumers know their individual health insurance will cover comprehensive hospitalization, maternity care, and prescription drugs with no lifetime or annual limits. People who maintain continuous coverage can change policies without incurring a new pre-ex. Premiums do not vary due to age, gender, or health status; and annual increases in premiums have been relatively stable, though coverage is not inexpensive.[13] Finally, New York's reforms are still in place. A substantial number of consumers participate in the market, and nearly all carriers in the market prior to reform have remained -- although all have converted their indemnity products to managed care.

The comprehensive nature of New York's reforms is one reason for these measures of success. It is very difficult for carriers to undermine risk spreading through subtle means, such as marketing practices or benefit design. The size of New York's individual market and the large average size of its individual carriers have also helped its reform to work. Approximately 700,000 New Yorkers buy individual health insurance, and New York had just 7 insurers per million population in 1997 – fewer than any other state (Thorpe, 1999; Chollet, Kirk and Chow, 2000). The size of New York's carriers supports risk spreading, and the division of the state into nine market regions promotes competition.

Even so, comprehensive reform has involved tradeoffs, and the debate over the future of New York's individual market reforms continues to be lively. Community rating led to higher rates for young and healthy people, and lower rates for older and sicker people.

[13] The cost of single coverage in most counties is $250 to $300/month or higher (New York State Insurance Department, http://www.ins.state.ny.us, February 2001).

Individual market participation has declined since reform as the healthy economy has drawn some participants back into the group market. But New York's loss of individual-market participation has been more precipitous than in states that did not reform their markets, and how much might be attributed to the multiple impacts of surging group coverage is unknown.[14] Certainly the average age of remaining individual market participants has increased – as has participation by the near elderly (aged 55-64) since implementation of community rating (Thorpe, 1999).

Carriers in New York complain their financial losses have been substantial. Following reform, many priced coverage to gain market share (and good risks) from their competitors -- hoping make up in volume what they ceded in average profits. However, when the entire market behaved this way, all carriers lost money without increasing market share. Because state regulators maintained prior approval of rates, annual premium increases have been limited. The fairness and adequacy of rates remains the topic of political debate.

New York's individual market reforms did not include subsidies for the purchase of private, non-group coverage. However, the Health Care Reform Act of 2000 (HCRA) indirectly subsidizes individual coverage, as of January 2001. This law established a "Direct-Pay Stop-Loss Fund" to pay 90% of carriers' claims above $20,000 per member per calendar year, up to $100,000 per year per enrollee. Financing comes mainly from tobacco revenues and must be renewed after a 2-1/2 year period. When total claims exceed appropriations, payments are to be reduced *pro rata*.

New York's Direct-Pay Stop-Loss Fund works in tandem with Healthy New York, a program that began in 2001. Healthy New York offers lower-cost coverage for low-income, working, uninsured New Yorkers and their families. Healthy New York's coverage is made less expensive by reducing covered benefits,[15] and the stop-loss program indirectly subsidizes its cost. The stop-loss for Healthy New York applies to the corridor of claims between $30,000 and $100,000 per member per calendar year. HMOs must participate in the Healthy New York program and other insurers may do so (NY State Insurance Department).

This approach is intended to attract younger and healthier people to the individual market, relieving pressure on health insurance costs and making the tradeoffs of reform

[14] Specifically, to the extent that rising group coverage draws lives from the individual market, it forces the insurers to spread fixed costs (marketing, administration, etc.) over fewer lives and puts upward pressure on insurance prices. However, rising group coverage may draw more of the better health risks in the individual market. "Biased" withdrawal of participants would leave greater health risks in the individual market, causing prices to rise even more.

[15] This benefit package is much less generous than the standardized coverage sold to other individual market participants. In particular, the prescription drug benefit is capped at $3,000 per person annually. The Healthy New York benefit package also is exempt from many state benefit mandates, including home health care, private duty nursing, and chiropractic care. Low-income sole proprietors and working individuals whose employers do not provide coverage are eligible to buy this policy. In addition, certain small employers with low-income workers can buy the Healthy New York benefit package.

less stark. However, because New York's public reinsurance fund is subject to a capped appropriation, the fund's ultimate payout – and its impact on premiums – may be modest. Early indications are that claims will exceed appropriations for the Direct-Pay Stop-Loss Fund for the first year. Further, individual market premium increases for the coming year are expected to be significant. By contrast, claims on the Healthy New York stop loss fund have been low because enrollment in the program has been low.

Debate over the advisability and direction of further reforms in New York continues. Consumer advocates have proposed transferring unused stop-loss funds for the Healthy New York program into the Direct-Pay Stop-Loss Fund to help reduce premium increases in that market. The Chamber of Commerce advocates yet another approach – permitting sole proprietors to purchase small group coverage through Chamber-sponsored purchasing pools. The insurance industry advocates making the Healthy New York benefit package available to all individual market participants as a way to bring down premiums (Scherzer).

New Jersey – New Jersey adopted comprehensive individual market reforms also in 1992. New Jersey required all carriers in the individual market to guarantee-issue all products, use pure community rating, limit preexisting condition exclusion periods, guarantee portability, and sell only standardized policies. New Jersey abandoned prior approval of premiums, but required insurers to achieve a minimum loss ratio of 75% on individual market policies to ensure that premiums were reasonably related to the cost of coverage. Insurers that fall short of the minimum loss ratio must return excess premiums to policyholders. Finally, the state reinforced its intention to spread risk broadly by requiring carriers either to participate in the reformed individual market or to pay an assessment ("play or pay") that offsets the losses of individual carriers.

Initially, New Jersey also operated a small subsidy program that appeared promising but was short-lived. Enrollment began in May, 1995, and closed that December. During those eight months, about 22,000 people enrolled in the program.

New Jersey's individual market reforms were a success story at their outset. Enrollment increased to almost 200,000 people by the end of 1995. Average premiums also increased, but HMOs were still offering standardized coverage for under $200/month as late as 1997. Individual premiums were higher than small group premiums, but still in line with the average cost of health care. Carriers appeared to be pricing coverage competitively to attract market share, not only the most attractive risks (Schwartz and Garnick, 2000).

Recently, however, New Jersey has encountered difficulties. In the last two years, participation in the individual market declined 50% and premiums have risen steeply. As in other states, the decline in individual coverage coincided with a sharp increase in small group market participation, and the average age of New Jersey individual market participants appears to be increasing – possibly reflecting greater job mobility and access to group coverage among younger workers, leaving older workers and retirees in individual coverage (Sanders, 2000).

More than a dozen carriers continue to offer coverage in the New Jersey individual market. All indemnity carriers charge much higher premiums in the individual market than for comparable coverage in the small group market. In the past few years, non-group premiums have escalated more rapidly than small group premiums, and only the standard HMO plans are still priced below $300/month for single coverage. Some individual indemnity carriers participate in this market only nominally, quoting very high prices for coverage.[16] Recent changes in the "play or pay" assessment formula permit this minimal participation without penalty (Sanders, 2000).

In the face of these changes, there has been political pressure to modify, if not repeal, New Jersey's individual market reforms. Proposals to reintroduce age rating and permit the sale of non-standardized products were considered in 2000 and may again be considered in future legislative sessions.

Kentucky and Washington – Two other states, Kentucky and Washington, tried comprehensive individual market reform but ultimately abandoned it. In both states, many small carriers left the market following reform, although many of them were writing little or no coverage. Nevertheless, their exit made a strong political statement. Also in both states, major carriers closed their books of business, refusing to accept new participants. Eventually, both states repealed most of their reforms.

Key factors contributing to the failure of reform in these states were, respectively, loopholes in their laws and problems that emanated from repeal of related laws. In Kentucky, the loophole occurred in the guaranteed issue requirement. Carriers in the individual market were required to offer all products to any applicant. However, they could continue to sell underwritten coverage to individuals through associations. All carriers (including the Blues) quickly established "air breather" associations – loosely defined associations formed essentially for the purpose of selling underwritten health insurance. Any consumer could join the association, but only those who could pass underwriting could buy inexpensive coverage. Those who could not pass underwriting were held in the reformed market. A selection spiral predictably resulted, and many carriers exited the reformed market. These events fueled a. political backlash that caused the entire reform approach eventually to be dismantled (Kirk, 2000).

In Washington a different series of events also resulted in repeal of extensive reforms in the individual market, but these ultimately were replaced by more moderate reform. Washington, too, had required guaranteed issue of all products at community rates and with strong portability protections for all residents. Washington's reforms became effective in 1994, and the Insurance Commissioner suspending even the shortened waiting period for coverage of preexisting conditions during initial open enrollment. A burst of new enrollment followed, none of it underwritten in the same ways as before, and a number of small commercial insurers left the state.[17] Some of this new enrollment

[16] For example, two national carriers, charge more than $4500/month for the standard Plan D policy (New Jersey Department of Banking and Insurance, 2000).

[17] All of Washington's departing insurers were based out-of-state, and they always had been at a competitive disadvantage with Washington's large domestic insurers, its Blue Cross Blue Shield plans and

was attributable to individuals leaving the state's high risk pool – which had been in operation prior to private market reform and which had publicly subsidized the cost of coverage for several thousand high risk individuals.

In 1995 – in the midst of the smaller insurers' departures – Washington repealed major components of its reforms. The reform law had phased in pure community rating, but it had never been fully implemented; the 1995 repeal statute allowed insurers to continue to base rates on age and other factors.

Despite this rollback, market change continued. The departure of Washington's smallest insurers redistributed very little business in its concentrated market, but following their departure Washington's Blue Cross and Blue Shield plans merged to form Premera Blue Cross. The Blues had been regional and had not directly competed, so their merger did not much change the nature of competition in Washington. But it did give them new political heft. Premera became the largest insurer of individual lives and the only insurer writing individual coverage statewide.

Although all insurers had certified that their proposed rates were adequate under a scenario of discontinued reform, following repeal they applied for significant rate increases, which the insurance commissioner denied. In November 1998, Premera announced that it would no longer sell new individual policies, precipitating a crisis in areas of the state where it was the only insurer of individual lives. Regence and Group Health, Premera's largest competitors, immediately requested and received permission to cease writing their mandatory standard policies which had the same benefit design as the state's public health insurance program – the Washington Basic Health Plan (BHP).[18] Nevertheless, in mid-1999, they also stopped writing all new policies. Thus, in 15 counties, residents could obtain individual coverage only from the BHP (Kirk, 2000). In many other counties (where Regence and Group Health had been writing the mandatory "BHP look-alike"), the BHP became the only source of significant coverage for pregnancy, mental health or substance abuse care, or for prescription drugs.[19]

Group Health. At least one of these insurers – Principal Mutual – had done a niche business in rich-benefit indemnity insurance, and open enrollment caused severe adverse selection in its business; notably, Principal Mutual soon also left the individual market nationwide. (Kirk, 2000)

[18] The Basic Health Plan (BHP) offered subsidized health insurance to low-income residents and sold unsubsidized coverage to any others who were interested. The BHP plan offered comprehensive health coverage that was also the basis for a standardized plan that all private carriers were required to sell in the individual market. Initially, carriers priced their BHP look-alike products slightly higher than the BHP, channeling adverse selection into the non-subsidized portion of this public program and driving up its rates. The Insurance Commissioner, however, refused to approve private carriers' proposed rate increases for their look-alike products. Before long, these products were cheaper than the BHP and adverse selection was sure to migrate back to them. Nevertheless, having experienced extreme adverse selection, the unsubsidized portion of the BHP was ultimately closed in 2000.

[19] The subsidized Basic Health Plan never experienced selection issues like those that plagued the unsubsidized plan and the private market, and this program remains in place. Almost 200,000 Washington state residents participate in this program; waiting lists have grown as large as 60,000. Premiums subsidies are available up to 200% of poverty. Subsidies also available for employer-sponsored coverage, but almost no employers participate -- apparently preferring to let employees take advantage of the individual subsidy.

In 2000, Washington enacted legislation that extended the preexisting condition waiting period (to 9 months, with a 6-month look back), created a standardized underwriting process, and gave high-risk individuals (calculated to be the highest-risk 8 percent of individual insurance applicants) access to a high risk pool. That legislation also required all that individual insurance products include certain benefits, including maternity. The state's dominant insurers supported this legislation, and all subsequently resumed writing individual coverage.

Summary - These states' experiences with comprehensive individual market reform, both good and bad, suggest several lessons.

First, insurers with larger premium volume find it easier to spread risk, although even the largest insurers may need time to adjust to major new reforms. The fact that individual markets are shrinking in every state poses a financial challenge especially to smaller insurers, making it even more likely that they would exit the individual market if confronted with significant reform.

Second, health insurance is characterized by economies of scale. Ongoing market pressures for insurers to become more efficient have caused many mergers and greater market concentration, especially in individual insurance markets. Small-population states have experienced dramatic market concentration, and many have only a few remaining carriers – although still an ample number relative to their population size. Due either to economic conditions or to regulation, market restructuring poses a challenge to regulators who have neither experience nor models for regulating highly monopolistic health insurance markets. Although highly concentrated insurance markets have been the rule for some time, the states' conventional view of these markets – that competition and new entry can mitigate the monopoly power of the largest few insurers – gives even small carriers leaving a state the leverage to precipitate fierce political fallout.

Third, loopholes undermine comprehensive reform. When insurers can re-segment risk, they will. As a result, reform that allows insurers to channel either good or bad risk systematically – either within the market or to public insurance programs that are unprepared for adverse selection – will create market instability, political pressure for rate adjustments, and a strong political dynamic for repeal of the reforms.

Finally, comprehensive reform involves tradeoffs. When access to market coverage is protected for everybody, coverage will become more expensive for some – perhaps most – consumers. These tradeoffs are hard for politicians and policy makers to weigh. They can be mitigated by carefully structured and targeted subsidies, but such subsidies can be difficult to design and to administer. Nevertheless, in a few states, reforms that offer public subsidies or risk sharing with insurers may bear watching as promising new models.

Incremental reform of the individual market

Most states have attempted incremental reform of their individual insurance markets. Again, the driving goal has been to assure access to coverage for at least some types of

residents who have been denied access. States with incremental reforms have not been as closely studied as comprehensive-reform states. What follows is a description of three types of state incremental reform approaches, all of which merit further study:

Portability – Portability reforms protect people who maintain continuous coverage from medical underwriting and from having preexisting condition exclusions restarted when they change health insurance plans. They typically do not help people who have had a lapse in coverage, though some portability states have adopted reforms to help this subset of the population as well. Some portability states protect only residents who are entering the individual market from group coverage. Others also protect residents moving between individual market policies.

Twelve states have adopted strong protections in their individual market for residents with prior coverage. Eight of these states protect access to individual coverage only for people leaving group coverage. The other four states protect any resident with prior coverage, group or individual, permitting residents to move freely from plan to plan within the individual market.

Florida, Georgia, Minnesota, Montana, Nevada, and Ohio require mandatory group conversion, with rules governing benefits that must be covered and rates that can be charged. This means group market carriers must offer to sell an individual product to their enrollees who leave the group because of a change in work status or family status. In 1997, Florida, Georgia, and Ohio expanded their laws to require guaranteed issuance of conversion coverage to federally eligible individuals leaving self-funded group health plans. Oregon offers another variation on this model: it requires all carriers in the individual market to offer coverage on a guaranteed issue basis to any resident with prior, fully insured group health plan coverage, but allows insurers to write only one standardized policy throughout the market. Rating limits apply to guaranteed-issue policies in all seven states. California protects only residents with prior group coverage (i.e., those who are federally eligible under HIPAA); however, it also limits what insurers can charge for this coverage.

These eight states' laws are similar to HIPAA in that they only help people entering the individual market when they leave group coverage. "Individual-to-individual" portability is not protected. However, these seven states are more protective than HIPAA because they limit rates that can be charged -- and in seven cases, they set standards for covered benefits.

Another portability model – used in Idaho, Iowa, Massachusetts, and South Dakota – protects consumers when they change individual policies.[20] All of these portability states designate a standardized product or products that must be guaranteed issue and that is

[20] Rhode Island is similar to these portability states in some respects. It requires all products in the individual market to be available on a guaranteed issue basis for any resident with at least 12 months of prior, continuous group or individual coverage. Importantly, however, Rhode Island does not regulate individual market rates.

subject to rating limits. However, entry into the individual market on a guaranteed issue basis is accomplished somewhat differently in different states. In Iowa, carriers can underwrite all applicants when they first apply for individual coverage, and those who are uninsurable can buy coverage from the state high risk pool. After one year in the high-risk pool, every enrollee is re-designated as insurable, and all individual carriers must offer them coverage. The other four states all require individual market carriers to offer coverage to all residents with prior coverage under a group or individual health plan. South Dakota residents must have at least 12 months of continuous coverage before they are eligible for guaranteed issue coverage. If they experience a lapse in coverage they will be subject to medical underwriting in the individual market. Any amount of prior continuous coverage qualifies Idaho and Massachusetts residents for a guaranteed issue policy. If there is a lapse in coverage, an individual will not again be eligible for a guaranteed issue policy until the next mandatory open-enrollment period.

Mandatory open enrollment periods and high-risk pools are key companion reforms in seven of these conversion/portability states, offering some access protection for people who have not maintained continuous coverage. (Four of these states have high-risk pools; two require mandatory open enrollment; and one has both.) Oregon further strengthens its market reforms through subsidies: the Family Health Insurance Assistance Program (FHIAP) is a small program that subsidizes the purchase of standardized private coverage for about 7,000 participants.

Taken together, these eleven states suggest that expansion of HIPAA may be possible on a nationwide basis. They have developed similar models for protecting access to the individual market that guarantee affordability and a minimum level of coverage, and they have experience guaranteeing individual-to-individual portability. In these eleven states, people who "play by the rules" and maintain continuous coverage can move into the individual market when they need to, even if they have a pre-existing condition.

High Risk Pools –States that have established high-risk pools permit medical underwriting to continue in the private market. The high-risk pool offers an alternative source of coverage for people whom insurers deny, offer substandard coverage or charge substandard rates. Though high-risk pools appear to be a relatively modest reform, to operate well they require a significant amount of resources and some fairly elaborate policy design.

Twenty-eight states operate high-risk pools as a source of health coverage for people determined to be "uninsurable" by private carriers in the individual market. In theory, states can let individual market underwriting practices continue, confident that a coverage haven will be available for people who are high risk.

High-risk pool enrollment is extremely small. Excluding enrollment in Tennessee's high-risk pool (which in 1994 was integrated into the TennCare program), approximately 101,000 persons nationwide were enrolled in the states' high-risk pools in 1999. Of these, nearly half (47 percent) were in either California's or Minnesota's high-risk pool (Communicating for Agriculture, 2000). Possibly due both to widespread public

awareness of the TennCare program and to consolidation of the eligibility determination process in Tennessee, estimated enrollment in the high-risk pool segment of TennCare is nearly as great as enrollment in all other state high-risk pools combined. Currently (in fiscal 2001), an estimated monthly average of 94,164 enrollees in TennCare — about 7 percent of all Tenncare enrollees — are eligible for TennCare because they are uninsurable (Price Waterhouse Coopers, 2000).[21]

Most states have struggled to fund their high-risk pools adequately. By definition, an insurance pool with only high-risk people will incur losses if premiums are constrained to be affordable. The states fund these losses with public dollars – typically an assessment on health insurance premiums. Facing political pressure to reduce taxes, many states have attempted to reduce pool losses in various ways.

Minnesota combines its individual market regulation (and other health reforms) to minimize the need for high-risk pool coverage. By tightly regulating its conversion market, Minnesota allows many leaving group coverage to bypass the medical underwriting that might place them in the high risk pool. MinnesotaCare – offering subsidized coverage for low-income residents – offers another important alternative. Minnesota's group-market rules discourage carriers from dumping high risks from the group market into the individual market and the high-risk pool. Even so, almost 26,000 Minnesotans were enrolled in the high-risk pool at the end of 1999. The pool offers comprehensive coverage and caps premiums at 125 percent of the average standard rate that private insurers charge to healthy individuals. Funding for the program is derived from several sources, including an assessment on health insurers and (temporarily) an excise tax on health care provider revenues.

Utah takes a somewhat different approach. It allows private insurers to cede very expensive health risks to the pools, but requires them to cover people who are merely above-average risk. The Utah high-risk pool re-underwrites all applicants whom private insurers have denied. Those they judge to be insurable are issued a certificate of insurability and any individual market carrier must then accept them (guaranteed issue). As described earlier, Iowa's high-risk pool employs a variant of this approach: it accepts individuals denied by private insurers and covers them for one year. After that, all enrollees are re-designated insurable and private insurers must offer them coverage.

These three states are unique in how they constrain the average cost of their high-risk pools. Many other high-risk pool states have had limited success in guarding the cost and instead have chosen to restrict enrollment (to constrain total cost), charge higher premiums, impose limits on covered services, or use some combination of these approaches (Communicating for Agriculture, 2000). For example:

- ten states set their high risk pool premiums at or above 200% of standard market rates;

[21]In a reorganization to become effective in fiscal 2002, TennCare will retain the State high-risk pool, but the financial management of this block of enrollees will be separate.

- two states cap enrollment when total high-risk pool costs exceed appropriations; another allows only HIPAA-eligibles to enroll;

- all state high-risk pools strictly limit coverage for mental health and substance abuse services;

- virtually all states significantly limit coverage for other services -- including inpatient hospital care (2 states), prescription drugs (6 states), maternity (10 states), home health (3 states), rehabilitation (5 states); and transplants (14 states);

- eight states impose a lifetime benefit limit less than $1 million; three also limit annual benefits (notably $75,000 in California).

As a result of these actions, many uninsurable residents may find their state high-risk pool coverage is unaffordable. Some who do enroll may find they are under-insured.

All state high-risk pools exclude coverage for pre-existing conditions for some period of time. Almost all will waive the pre-existing condition exclusion for new enrollees with continuous prior coverage if it was involuntarily terminated (although one state charges a higher premium for this waiver). The extent to which these exclusion periods present a barrier for applicants who have ongoing health problems has not been researched. However, for uninsured individuals or for people who have been able to afford health insurance only intermittently, they may be a strong deterrent to enrolling in the high-risk pool.

All state high-risk pools use age rating. Premiums for older enrollees, therefore, can be quite high**.** A 62-year-old man electing a $500 deductible option, for example, would pay a monthly premium of up to $531 for high risk pool coverage in Colorado, $746 in Texas, $980 in Illinois, and $1,015 in Alaska (Communicating for Agriculture, 2000).

A few states have walked away from their experiment with high-risk pools. Maine and South Dakota repealed their high-risk pool laws, and Florida's pool has been closed to new enrollment since 1991. California's high-risk pool (currently closed to new enrollment) has been intermittently closed in past years due to cost. Tennessee took advantage of federal Medicaid waiver authority to refinance its high-risk pool, merging it with TennCare in 1995, so that the federal government pays more than half the cost.

Several other states have recently started new pools. Texas and Alabama enacted high-risk pool legislation to comply with HIPAA (Alabama's pool is open only to HIPAA eligibles.). Washington reopened its high-risk pool to new enrollment in 1999-2000 as that state's individual market reforms were repealed. Idaho opened a high risk pool in 2001.

Six state pools offer premium subsidies to their low-income enrollees, although they are modest. These states subsidize high-risk pool premiums (which always are set at higher-than-standard rates) so that they equal standard rates.

In summary, state high-risk pools offer people who are uninsurable an important coverage option, but the states have found that it is expensive to finance coverage for all those whom private insurers reject. Some states spread the cost of high-risk individuals across insurers, taxing premium revenues or insured lives to pay for high-risk pool losses.[22] Others attempt to control costs by limiting enrollment, limiting covered benefits, increasing cost sharing, and raising premiums. At the extreme, some state high-risk pools offer the appearance of a safety net, but in reality protection is very limited.

Alternatives to individual market coverage – Most states have guaranteed access to group coverage for a subset of their residents who would otherwise need individual market coverage. In some states this guaranteed access to group coverage appears to be in lieu of individual market reforms. In others, these are companion reforms.

Thirteen states permit self-employed residents without employees to purchase small group health insurance as a group of one. All of these states have adopted more generous access protections in their small group markets than in their individual markets – that is, group market coverage is guaranteed issue and rates are regulated. Therefore, the self-employed in these states are shielded from the impact of medical underwriting.

The impact these provisions may have on the residual individual market is hard to gauge. States that grant the self-employed access to group markets have potentially reduced the pool of individual market participants (nationwide, the self-employed comprise about one-fifth of all individual market participants). In addition, adverse selection may occur between the individual market and the small-group market, especially if the small group and individual markets regulate medical underwriting differently. For example, in states like Colorado (which requires guaranteed issue and community rating in the small group market but not in the individual market) the self-employed may sort themselves by risk – with younger, healthier people taking advantage of underwritten rates in the individual market. In general, selection issues might be less problematic in states where individual and small group market rules are parallel.

Thirty-six states have enacted "mini-COBRA" laws, granting temporary continuation of coverage rights to people leaving small employer plans. State mini-COBRA laws vary significantly. Some apply continuation rights comparable to those in COBRA to all fully insured small groups with 2-19 employees. Others provide for more limited protections – for example, only 3-6 months of continuation coverage – only for certain people leaving certain small group plans. However, in all states continuation allows people to avoid or delay the need for individual market coverage. People who elect state continuation coverage probably are older or sicker, as is the case for people who elect COBRA

[22] In states that allow insurers to offset premium assessments against their income tax liability, high-risk pool losses are in effect funded from the state's general revenues.

continuation. As a result, mini-COBRA laws may have improve the average risk in the individual market if they siphon off older and sicker individuals.

Finally, New Mexico is unique in providing some individuals access to coverage through its small-employer health insurance alliance. Many self-employed people can buy group coverage in the Alliance like other small employers.[23] For a slightly higher premium, HIPAA eligibles can buy individual coverage in the Alliance that is identical to group coverage. Finally, people leaving a small-employer Alliance health plan have conversion rights: they can keep their small group plan and pay the higher individual rate; and they can retain Alliance coverage indefinitely, even if they move out of the state. The Alliance offers both indemnity and HMO coverage. All plans cover a minimum set of benefits (required by a Board of Directors), including maternity and mental health care and limited prescription drug coverage. Premiums are set by modified community rating. During an annual open season, participants can change plans, subject to certain rules. As of January 1, 2001, the New Mexico Health Insurance Alliance provided coverage for more than 9,000 lives (Pollitz, *et.al*, 1998; Shelton, 2001).

Summary – State experiences with incremental reform suggest some models to study and some to avoid. A number of states have acted to protect access to coverage for a subset of their residents. Often this protected class contains people who have "played by the rules" by maintaining continuous coverage. Some states have provided time-limited protection to these people through mini-COBRA laws – protecting access to group coverage for certain people who might otherwise need individual market coverage – and longer term protection through portability reforms. A number of states have identified the self-employed as deserving special access protection. All of these measures spread the risk of these protected individuals broadly over their insurance markets, individual and group.

Many states have decided to let risk selection continue in the individual market, but to offer a high risk pool as a safety net for individuals whom private carriers reject. By and large, these states have found their high-risk pools to be exceedingly expensive. A few states have found ways to provide meaningful, affordable coverage through high risk pools, but many more struggle to finance the cost of covering everyone whom the private market rejects; and have responded by setting high premiums, limiting coverage, and limiting enrollment.

Every incremental reform involves tradeoffs. While subsidies may soften these tradeoffs, most states are reluctant to commit new state funds to resolve their coverage problem. In the past, major improvements in coverage have been achieved only through partnerships with the federal government. The next section of this paper explores possible federal initiatives to expand individual market reform and the affordability of coverage.

[23] Self-employed persons who buy family coverage for at least one dependent are counted as a group. In addition, minimum participation standards for small groups are very lenient: a small business owner with a single employee can buy group coverage for himself even if the employee declined health benefits.

IV. FUTURE FEDERAL INITIATIVES IN INDIVIDUAL MARKET REFORM?

It is significant that virtually every state has acted in some way to limit the access problems caused by medical underwriting in the individual market. Even so, state actions are varied, and many have met with only mixed success. At the federal level, HIPAA established a national floor – albeit a low one – for protecting access to individual market coverage. This floor could be raised, reinforcing many state efforts and strengthening to individual market coverage for more people nationwide.

The direction federal initiatives might take, and how far they should go, is a judgment call. Options explored in this section include:

- Improve but not expand HIPAA – If federal policymakers decide against expanding individual market access as a near-term goal, they could nonetheless make changes to HIPAA that would make it work better for those individuals it already protects and make it a better floor on which to build future reforms;

- Strengthen the safety net for uninsurable individuals – The federal government could promote high risk pool improvements to make coverage more comprehensive and affordable for people denied in the individual market;

- Offer alternatives to individual market coverage – The federal government could promote group market reforms or public plan expansions to permit certain people to gain coverage through these sources, instead of in the individual market;

- Expand HIPAA – The federal government could amend this law to strengthen protections for people with prior coverage, either to ease their entry into the individual market, to protect their portability between individual market plans, or both;

- Promote comprehensive individual market reform – The federal government could protect access to coverage for all participants in the individual market, allowing states to use various alternative models.

A brief discussion of these general options follows. We then turn to the current debate over tax credits for individual health insurance and review the need for market reform in the context of that proposal.

Option 1: Making HIPAA work better

Building on the current floor of individual market access protections could begin with some relatively simple changes to HIPAA to make it work better for the few people it does help and to make it a stronger base for future reform. These would include:

- supporting toll-free hotlines and other consumer assistance to help the public understand and pursue the protections that HIPAA guarantees;
- modifying certificates of creditable coverage to include an explanation of HIPAA individual market rights and to indicate where consumers should call for more information;
- setting tighter rules for the timely issuance of certificates of creditable coverage;
- developing and requiring the use of standard terminology to describe HIPAA-eligible individuals and the insurance products for which they qualify so that people could identify and find protected coverage more easily;
- collecting data on number and types of people who become federally eligible, where they obtain coverage, what their policies cover and cost, and how long they hold the protected coverage; and
- expanding information sharing between federal and state insurance regulators in order to strengthen oversight and enforcement.

These modest changes would make limited HIPAA protections more understandable and accessible to people who need them. A meaningful expansion of access protections in the individual market, however, will require moving beyond the limited provisions of HIPAA.

Option 2: Strengthening high risk pools

The federal government could act to strengthen high-risk pools so that people denied coverage by private carriers have better access to coverage than they do now. People in high-risk pools ought not to be underinsured, as many are today. Federal minimum standards could make these safety nets more meaningful, including:

- lower deductibles and other cost sharing;
- no annual limits on covered benefits;
- no lifetime limits, or substantially increased ceilings (at least $2 million);
- reasonable out of pocket maximums;
- no inside coverage limits on hospital, prescription drugs, or other major benefit categories;
- lower premium caps;
- no or limited age rating;
- no enrollment caps; and
- a waiver of pre-ex waiting periods for prior creditable coverage

Strengthening the insurance safety net for the uninsurable might seem like a modest federal reform increment. But improvements like these could be expensive unless they are accompanied by companion reforms to limit the risk that private carriers cede to high-risk pools. Minnesota, Utah and Iowa offer different models for this, as does Washington's new high-risk pool. Even with these reforms, many states might need financial assistance to implement or improve their high-risk pools and to cover their losses. Extending such federal financial assistance would undoubtedly prompt states that do not have high-risk pools to establish them or to request comparable assistance to support other types of market reforms. In short, strengthening high-risk pools has the potential to help many vulnerable individuals across the nation, but such an initiative would require other market reforms and/or subsidies.

Option 3: Finding alternatives to individual market coverage for some participants

The federal government could promote access to other kinds of coverage for certain people who now rely on the individual market and who are especially vulnerable there. Examples include allowing the self-employed to access to small group coverage. Alternatively, the federal government could permit individuals to buy coverage through its public employee plans (FEHBP), or assist states in designing and implementing a buy-in to their state employee health programs or to a broad purchasing cooperative that would include employer groups (as in New Mexico). Finally, the federal government might again consider allowing early retirees to buy into Medicare, a proposal that triggered some policy analysis and debate in 1999. In addition to opening coverage options for early retirees, this proposal also could relieve state individual markets of some of their most expensive risks.

Option 4: Building on HIPAA portability protections

HIPAA could be expanded to strengthen its protections and to make more individuals eligible for them. Building on the experience of a number of states, HIPAA eligibility could be expanded to include individuals with 12 months of prior continuous coverage. Alternatively, portability protection might be extended to people changing policies within the individual market, as HIPAA now protects people changing group policies. The content of HIPAA individual market protections also could be expanded generally to parallel consumer protections in the group market, making the definition of a pre-existing condition could uniform and prohibiting exclusion riders. In addition, comprehensive standards for the content of coverage could be developed (as several states have done), and consistent minimum rating limits could be established. Finally, federal subsidies could make premiums more affordable for modest income individuals and families.

Building on HIPAA in these ways would raise the federal minimum floor of protections for people in the individual market. The fact that so many states now achieve these protections in a variety of different ways suggests that state flexibility could continue to be an important feature in any HIPAA expansion.

Option 5: Comprehensive individual market reform

Finally, the federal government could pursue comprehensive individual market reform nationwide. All products in the individual market would be offered on a guaranteed issue basis to all participants, continuously. Rating limits would apply to all policies, and standardized benefits could be developed. This is the most ambitious approach, technically and politically, especially if pursued on a state-by-state basis. In the absence of significant federal support – both financial and technical – many states could be expected to struggle with this reform agenda. Many might need to consider designing more comprehensive management of their individual health insurance market – such as Minnesota is now considering. Comprehensive public management might entail forming a single large risk pool of all individually insured lives, with insurers bidding on the average risk in the pool and also sharing losses (as they do now) in the high-risk pool. Such a market might be fairer to consumers as well as insurers, and also more stable as group coverage changes with the economy and the nature of employment.

Coverage expansion through refundable individual market tax credits

Beyond the narrow discussion of individual markets, the national debate over the uninsured continues. Competing strategies have been proposed to cover some or all of the 42 million Americans who are uninsured. Among these are proposals to give people refundable tax credits to make individual health insurance more affordable. The broader debate about the uninsured and the relative advantages of different coverage strategies is beyond the scope of this paper. Instead, we will look at how tax credits might work in today's individual markets and what market reforms might be needed to make tax credits work.

No refundable tax credit proposal is yet in the lead, although President Bush set aside funds for such a credit in his fiscal year 2002 budget. Senators Jeffords, Breaux, Frist, Lincoln, Snowe, Chafee and Carper have introduced legislation to provide a refundable credit of up to $1,000 for an individual and $2,000 for a family.[24] These and other proposals offer the general design of for this kind of subsidy, but lack many specifics.

Economists Jonathan Gruber and Larry Levitt (2000) modeled the impact of several types of refundable tax credits on coverage expansion. The basic subsidy they modeled was a refundable tax credit capped at $1,000/person or $2,000/family. This credit was further modified so that it could be claimed throughout the year, not just at filing. Only non-group coverage expenses would be eligible for the credit. Gruber and Levitt estimated that this refundable tax credit would reduce the number of uninsured by just over 4 million people, but over 18 million people would claim the credit. They estimated that half those claiming the credit would be people who are currently participating in the individual market, and another 5 million would be people who were previously covered under employer-sponsored coverage or Medicaid. In all, they estimated the individual market would grow by almost 10 million participants.

[24] S. 590.

Adding this many participants to the individual market would undoubtedly strengthen it. Even the smallest insurers might gain a larger base of lives over which to spread risk. Further, a tax-subsidized market might be less prone to adverse selection and more stable; consequently, it might also tolerate market reforms that are less feasible when markets are very small and enrollment more volatile. Carriers in an expanded market might also enjoy greater economies of scale and operate more efficiently, reducing cost.

However, offering a subsidy for individual coverage without further market reform would force an immediate confrontation with the many problems in this market today. Absent any change in market regulation, insurers would be able to select risk as they do today, and would still be inclined to underwrite aggressively, if only in defense against underwriting by their competitors. Significant numbers of people who have health problems remain unable to obtain coverage, or they would continue to be offered only coverage that is inadequate or unaffordable. As a share of premium, a fixed-amount subsidy would benefit principally younger, healthier and more affluent market participants. All others – those who do not now fare well in the individual market – probably would not fare appreciably better, but at much greater public expense. And some might be worse off, if their employers stop offering health benefits with more generous coverage and sent their employees to the individual market. Finally, considering most states' well-known problems of access and affordability in the individual market, a tax subsidy for individual coverage without reform would probably trigger a public relations crisis: the public is unlikely to appreciate a health coverage expansion that is, in effect, denied to sick people.

What reforms would need to accompany a refundable tax credit to assure that all who take the credit would be able to obtain adequate, affordable coverage? First, access to some coverage would have to be guaranteed. The guaranteed-issue requirement might apply to all individual health policies, only to designated policies, to a state high-risk pool, or to some other designated public program. If high-risk pools are designated as the ultimate source of coverage, additional reforms would be needed to protect the public program from carriers who would dump risk into it. Also, the states probably would insist on federal financial assistance to operate their pools. Without financial help, the states would be left to finance the excess cost of care for high-risk people who claim the tax credit; thus, they might view a tax credit without additional financial assistance as an unfunded mandate.

Second, portability protections parallel to those now required under HIPAA for group market coverage would need to be added to the individual market. Limits on pre-existing condition exclusion periods would need to be tightened, and credit for prior coverage recognized. This would enable individual market participants to move and change plans, regardless of health status, so long as they maintain continuous coverage.

Third, some standard for meaningful content of coverage would have to be assured. This is likely to entail prohibitions on exclusion riders as well as other benefit adjustments that insurers commonly make on the basis of medical underwriting. It might also entail establishing a comprehensive minimum-benefit policy in lieu of the scatter-shot benefit mandates that prevail in most states. Special attention would have to be paid to certain

benefits – maternity care, mental health and substance abuse treatment, and prescription drugs – and to cost sharing options that insurers commonly curtail or eliminate to achieve favorable selection. And finally, the standard benefit would itself have to be protected from adverse selection; several states continue to protect their market reforms by prohibiting the sale of nonstandard products in the individual market.

Fourth, adjustments would be needed to assure the tax credit would help older and sicker people buy affordable coverage. The tax credit could be adjusted for age, gender, health status, geography, and other factors. However, this approach might not be practical, given the enormous premium variation that exists today; at the extremes, some taxpayers would need a credit that is 40 to 50 times greater than others. Alternatively, federal government could limit rating variation in the individual market based on health status, age, gender and geography; or it could adopt some combination of market rating limits (for example, based on health status) and tax credit adjustments (for example, for age, gender, and geography). In the absence of such adjustments, any likely maximum credit amount would probably be insufficient to help people in some demographic categories or geographic areas. Many – perhaps most – people in high rate classes probably could afford only part-year coverage (as little as a month or two), until the amount of the monthly premium exhausted the annual tax credit. Or if the credit were prorated to monthly coverage, they could not afford it at all.

Fifth, the tax credit would need to be scaled to income, so that low-income uninsured people would be able to use it; at higher incomes, the credit could be phased out to hold down the overall cost of the tax subsidy program. A partial subsidy would not be effective in expanding coverage to the uninsured: the vast majority have incomes below the median income of families in the U.S. (about 300% of poverty), and most have incomes below 200% of poverty. Offering this population a partial subsidy to afford full-year coverage is like offering a ten-foot rope to someone at the bottom of a thirty-foot hole. Alternatively, policy makers might require that every state make available to all residents at least one "zero-premium" plan priced at the tax credit. Coverage under the zero-premium plan would have to meet minimum benefit standards to avoid selection problems.

Sixth, states would need to provide some assurances to the federal government that they have adopted and enforced these market reforms. Where they do not, as HIPAA now provides, the federal government would need to step in to make individual markets work, and it would need to be prepared to do so.

Finally, at least two other important policy issues, beyond the scope of this paper, also would need to be considered. The impact of individual market tax credits on employer coverage is a critical issue. To avoid a significant shift of population from group coverage to the individual market, employee contributions toward group health plan premiums might also be made eligible for the tax credit. But expanding the use of the tax credit would have other implications for its cost, in part due to the much greater number of people who would claim it.

Coordination with Medicaid and with the newly enacted children's health insurance programs is also essential. All states now subsidize coverage for at least some residents above the poverty level. Would states encourage their Medicaid and S-CHIP beneficiaries to move out of state-funded programs into federally subsidized private policies? Or might federal law allow individuals to use their tax credit to buy into Medicaid and S-CHIP?

Summary

Whether the goal is to expand the individual market to cover more people or to make the existing market function better for those who rely on it now, there is a substantial body of state and federal reform experience from which to learn and on which to build. States have experimented with a variety of models to spread risk and to promote access to coverage in the individual market -- sometimes for all residents, sometimes for only a subset. These experiences suggest that further efforts to strengthen individual markets, even incremental efforts, are warranted and that they can succeed. Future federal initiatives can incorporate the ample lessons offered by past and ongoing state efforts. The addition of federal resources and other assistance can reinforce and encourage further state efforts to improve access in the individual market.

V. FUTURE RESEARCH NEEDS

Additional research on the individual market would inform the public policy proposals now being debated at the state and federal level. Research also would inform federal and state policymakers interested in evaluating the effectiveness of public policies that have already been enacted to regulate this market.

Basic data collection

An individual market research agenda could start with collection of more and better data on this market, its consumers, participating carriers, and products. States traditionally have obtained sparse data on their individual markets. Most regulators are unable to say with any precision how many lives are covered in this market, how many carriers are actively writing coverage, what benefit designs prevail, and at what price. Some states are improving their reporting requirements to obtain some of this information routinely. A review of existing data sources on a state-by-state basis and model reporting systems would inform federal and state policy makers about information gaps and potential best practices for filling them.

An ongoing database about state individual market regulatory rules and practices would also be a useful resource to federal and state insurance regulators, as well as to researchers. A compilation of regulatory rules, if periodically updated, would provide information to regulators about their own market rules relative to those in other states. And it would facilitate evaluation of how different regulatory frameworks affect market operations and consumers.

Regulatory models and market structure

The small size of the individual market is a theme that cuts across many of its issues and problems. Further research into the regulation of small markets – including proposals to expand them – is advisable.

Regulating small markets - In most states, the individual market is characterized by a large number of carriers relative to the number of covered lives. Very small states typically have only a handful of carriers, but compared to large-population states they have many more carriers per capita. These markets should be studied to learn more about the implications for consumers, insurers, and regulators when only two or three carriers serve a market. Research into models for regulating other kinds of monopoly or oligopoly markets – for example, the experience of public commissions such as those that might oversee public utility or community hospital operations – could be valuable in developing models for insurance regulators in these states. What is known about promoting efficient and stable supply in such markets? What are the implications for cost and consumer choice? Politically, what dynamics do policy makers and regulators face when making policy for such a concentrated market?

Regional individual markets – Officials and researchers in New England have occasionally engaged in discussions about creating a regional individual market – an

insurance common market. This idea may help to improve efficiency in the individual market. That is, by promoting consistency in insurance practices throughout the region, it might in effect expand the states' common risk pool and reduce redundant costs. Yet, blurring state jurisdictional boundaries also raises many legal, regulatory and political issues. This concept of regional health insurance markets and how they might work merits further study and analysis. A case study could explore the application of this concept to the specific circumstances in New England, and also among other states with small populations.

Stabilizing markets

Risk spreading also has potential to help stabilize individual markets. State strategies that have been tried to date should be better documented and understood.

Reinsurance – States have experimented with different models to help spread and subsidize risk in the individual health insurance markets. Further research to describe these models and analyze their impact could investigate:

- corridor reinsurance approaches, like that underway in New York
- revenue redistribution, like that tried and amended in New Jersey
- loss and gain sharing, as is newly in place in Tennessee's TennCare program.

A review of some of these models and their impact on carriers, the cost of coverage, and access to coverage would be a valuable addition to what is known about the individual market.

High risk pools – In effect another reinsurance model, state high risk pools are structured in a number of different ways. Because these pools remain a popular policy option – and because many of them have problems in common – they should be studied more closely. Innovative approaches to coordinating high-risk pool coverage with carrier underwriting practices (as in Utah, Iowa, and Minnesota) may provide valuable lessons for other high risk pool states. In addition, the content and cost of high-risk pool coverage merits a closer look both from a government fiscal perspective and from the perspective of consumers who rely on this coverage.

Market reforms to promote access

Medical underwriting is another crosscutting theme in the individual market. The barriers to coverage this practice creates, the effect on markets and the impact on coverage when regulation curtails underwriting in a voluntary market merit further study and documentation. Clearly, the states have taken various regulatory approaches to constraining insurer underwriting. Less clear, however, is how these regulatory approaches compare in effectiveness, or how they compare to other models (such as high-risk pools) alone or in combination. The list of potential research topics in this field is potentially extensive. We suggest a few topics here that could be timely and interesting:

Portability models - State models to promote portability into and within the individual market should be studied in more depth to understand how these approaches depart from

HIPAA. As federal evaluation and oversight of HIPAA proceeds, other state portability reforms should be analyzed to compare the effect of different approaches on access to coverage and on the cost of coverage. Comparison case studies could be especially valuable – for example, comparing access to individual market coverage for people losing group coverage in North Carolina (which only provides HIPAA mandated protections to federally eligible individuals) vs. Oregon (where more comprehensive portability protections are in place).

Impact on consumers by health status - Additional research is needed to understand the impact of medical underwriting on access to individual market coverage by people with health problems (current, past, and predicted by genetic information.). Population-wide measures of denial rates (and rates of substandard coverage or premiums) would be needed to develop targeted regulation of insurer underwriting and also support estimates of the potential impacts and cost of policies to subsidize coverage, spread risk and enhance access for the uninsured.

Renewal rating practices - The experiences of sicker individuals with individual coverage should be examined over time, as well as at the point of initial access. Renewal rating practices need to be better documented and studied, as well as the emergence of plan modifications that can undermine the protection of guaranteed renewal. Anecdotal evidence about "manual rate increases" could be investigated and confirmed. Other insurer practices that affect renewal rates (including the opening and closing of policy forms) also should be studied.

The individual market and other markets

More needs to be known about why and how frequently people enter and leave the individual market. Understanding the magnitude of entry and exit, and what factors prompt and hinder it, could inform future consideration of portability protections and measures to pool risk more broadly. For example, as the economy and employer-provided coverage expand or contract, what is the impact on the individual market? How many people in the individual market remain there for a year or more? How many low-income participants in the individual market enter from group coverage?

More may be learned from states that have blurred the line between their individual and small group insurance markets. The New Mexico experiment with its small employer health insurance alliance is especially interesting and unique and worthy of further study. Can this experiment offer lessons or models for other states that seek to manage private markets so that they will be accessible to individuals and very small groups that might not otherwise participate in coverage? In other states that permit groups of one access to small group market coverage, what choices do self-employed people make?

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